STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155361	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBER MANOR CARE CENTER	801 E ILLINOIS ST PETERSBURG, IN 47567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 18, 19, 21, 24, 25, 2011 Facility number: 000252 Provider number: 155631 AIM Number: 100267780 Survey Team: Terri Walters RN TC Martha Saull RN Elizabeth Harper RN 1/18/11, 1/19/11 Carole McDaniel RN 1/24/11, 1/25/11 Census Bed Type: SNF: 5 SNF/NF: 51 Total: 56 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 22 Total: 56 Sample: 14 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 1/31/11 by Suzanne Williams, RN	F 000	The submission of this plan of correction does not indicate an admission by the Amber Manor Care Center that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Amber Manor Care Center. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

RECEIVED
FEB 17 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Griffith	Executive Director	2-14-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 225	F 225 No residents were affected by the alleged deficient practice **Completion Date 2-16-2011** All residents have the potential to be affected by the alleged deficient practice therefore through systematic changes stated below the campus will ensure the abuse prevention policy and procedure is followed. **Completion Date 2-16-2011** All campus staff has been in serviced regarding investigation procedures and requirements of reporting all allegations immediately to the Executive Director **Completion Date 2-16-2011** Systemic change is Campus to complete a quarterly in service concerning abuse prevention procedure **Completion Date 2-16-2011**	

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F 225	Continued From page 2 failed to ensure the Administrator was immediately notified of a resident's allegation of a staff member acting inappropriately, and failed to investigate the incident and report the incident to the state agency, for 1 of 1 resident reviewed for an allegation of abuse in a sample of 14. (Resident #32) Findings include: Resident #32's clinical record was reviewed on 1/18/11 at 4:12 P.M. Her current Minimum Data Set assessment (MDS) dated 12/27/10, indicated her cognition was intact. A MDS assessment, dated 5/11/10, indicated no cognitive impairment. A nursing note dated 9/19/10 at 1:15 P.M., indicated, "Res (resident) resting in bed. CNA enters room to speak c (with) Res. roommate, activities enters room behind CNA et (and) Res yells out - 'Hey you' - to activities - 'That girl there picked me up et threw me in bed et twisted my ankle.' Res crying @ this time. Res. nurse had just been in c Res. et res was fine et voiced no c/o (complaints)." A nursing note dated 9/19/10 at 1:30 P.M., indicated, "Res resting in bed. No c/o voiced." A nursing note dated 9/19/10 at 1:50 P.M., indicated, "MD notified of the above." On 1/24/11 at 11:30 A.M., the Director of Nursing (DON) was interviewed regarding Resident #32's allegation of abuse documented in the nursing note of 9/19/10. She indicated all the information regarding the allegation was in the nursing note (9/19/10).	F 225	ED/ designee will administer a post test to 2 random campus staff to verify understanding of abuse prevention procedure 5x a week x one month 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 2-16-2011**	

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F 225	Continued From page 3 On 1/25/11 at 10:00 A.M., the Administrator was interviewed regarding the allegation of abuse in the nurse's note of 9/19/10. She indicated she had not been notified of this allegation. The facility's abuse policy (not dated), entitled "Abuse and Neglect Procedural Guidelines," was reviewed on 1/24/11 at 11:00 A.M. This policy included, but was not limited to: "...Prevention 5. Staff is required to report concerns, incidents, and grievances immediately to your manager and/or Executive Director and Director of Health Services... d. Identification ii. Any person with knowledge or suspension of suspected violations shall report immediately, without fear of reprisal. 1. ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY IS A CRIME AND MAY RESULT IN THE LOSS OF PROFESSIONAL LICENSE OR NURSING ASSISTANT CERTIFICATION. iii. The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...." 3.1-28(c) 3.1-28(d) 3.1-28(e)	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure their abuse prevention policy and procedure was implemented, by failing to ensure the Administrator was immediately notified of a resident's allegation of a staff member acting inappropriately and failing to investigate the incident and report the incident to the state agency, for 1 of 1 resident reviewed for an allegation of abuse in a sample of 14. (Resident #32) Findings include: Resident #32's clinical record was reviewed on 1/18/11 at 4:12 P.M. Her current Minimum Data Set assessment (MDS) dated 12/27/10, indicated her cognition was intact. A MDS assessment, dated 5/11/10, indicated no cognitive impairment. A nursing note dated 9/19/10 at 1:15 P.M., indicated, "Res (resident) resting in bed. CNA enters room to speak c (with) Res. roommate, activities enters room behind CNA et (and) Res yells out - 'Hey you' - to activities - 'That girl there picked me up et threw me in bed et twisted my ankle.' Res crying @ this time. Res. nurse had just been in c Res. et res was fine et voiced no c/o (complaints)." A nursing note dated 9/19/10 at 1:30 P.M., indicated, "Res resting in bed. No c/o voiced." A nursing note dated 9/19/10 at 1:50 P.M., indicated, "MD notified of the above." On 1/24/11 at 11:30 A.M., the Director of Nursing (DON) was interviewed regarding Resident #32's	F 226	F 226 No residents were affected by the alleged deficient practice **Completion Date 2-16-2011** All residents have the potential to be affected by the alleged deficient practice therefore through systematic changes stated below the campus will ensure the abuse prevention policy and procedure is followed. **Completion Date 2-16-2011** All campus staff has been in serviced regarding investigation procedures and requirements of reporting all allegations immediately to the Executive Director **Completion Date 2-16-2011** Systemic change is Campus to complete a quarterly in service concerning abuse prevention procedure **Completion Date 2-16-2011**	

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F 226	Continued From page 5 allegation of abuse documented in the nursing note of 9/19/10. She indicated all the information regarding the allegation was in the nursing note (9/19/10). On 1/25/11 at 10:00 A.M., the Administrator was interviewed regarding the allegation of abuse in the nurse's note of 9/19/10. She indicated she had not been notified of this allegation. The facility's abuse policy (not dated), entitled "Abuse and Neglect Procedural Guidelines," was reviewed on 1/24/11 at 11:00 A.M. This policy included, but was not limited to: "...Prevention 5. Staff is required to report concerns, incidents, and grievances immediately to your manager and/or Executive Director and Director of Health Services... d. Identification ii. Any person with knowledge or suspension of suspected violations shall report immediately, without fear of reprisal. 1. ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY IS A CRIME AND MAY RESULT IN THE LOSS OF PROFESSIONAL LICENSE OR NURSING ASSISTANT CERTIFICATION. iii. The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...."	F 226	ED/ designee will administer a post test to 2 random campus staff to verify understanding of abuse prevention procedure 5x a week x one month 3x a week x one month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 2-16-2011**	
F 250 SS=D	3.1-28(a) 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

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F 250	Continued From page 6 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure observed behaviors and psychosocial needs were documented, monitored and addressed, for 1 of 3 residents reviewed with behaviors and/or psychosocial symptoms in a sample of 14. Resident #14 Findings include: 1. The clinical record of Resident #14 was reviewed on 1/18/11 at 3:10 P.M. Diagnoses included, but were not limited to, the following: dementia with behavioral disturbances and psychosis. The most recent MDS (Minimum Data Set assessment) dated 12/31/10, indicated the following for the resident: cognitive summary score was zero, which indicated a severe cognitive impairment; symptoms present of mood were identified as "no response." A psychiatric evaluation, dated 9/11/10, indicated the following: Diagnoses: "...beh (behavioral) disturbances/psychosis...anxiety/...dep (depressive) disorder...initial treatment plan: increase Zyprexa (antipsychotic medication) to 5 mg bid (twice a day)...c/o (complaints of): ...referred from medical floor after she received blood transfusion. She originally came from (name of nursing home) through the ER (for low hemoglobin) ...Res (resident) very paranoid, yelling ...symptoms: depressed, crying, lack of interest: mental status exam: depressed and	F 250	**F 250** Resident #14 no longer resides in the campus. **Completion Date 2-16-2011** All residents have the potential to be affected by the alleged deficient practice and therefore through alterations in processes and in servicing the campus will ensure it provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. **Completion Date 2-16-2011** All campus staff has been in serviced on appropriate response to a behavior and required documentation of that behavior. Campus nurses have been in serviced on using the new assessment titled Mental Wellness Circumstance, Assessment and Intervention form when a new or an exacerbation of a behavior occurs. **Completion Date 2-16-2011**	

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F 250	Continued From page 7 scared...." A behavorial health progress note, dated 9/15/10, included, but was not limited to, the following: "Mood: OK" (depressed was an option but was not checked). A "Hospice" plan of care was dated 12/10/10. Interventions included, but were not limited to, the following: "Allow resident to discuss painful feelings if able. Do not deny death if resident wants to talk about it." Nurses notes, dated 12/28/10 (sic), at 2300 (11 P.M.), indicated the following: "Res (resident) very tearful saying 'I want to go home.' All attempts made to comfort res refused ...Hospice nurse updated on res condition et (and) tearfulness at this tx (time). Hospice nurse stated she would see res in AM (morning) et (and) contact Dr. (physician name) with update." Nurses notes, dated 12/28/10 at 0946 (9:46 A.M.), indicated the following: "Res. cont. (continue) with hospice care services. Res. has been very tearful. Res. has not wanted to eat...." Hospice nurses notes, dated 12/30/10, included, but were not limited to, the following: "tearful at times, tearful, wants to go home...." Hospice nurse notes, dated 1/6/11, included, but were not limited to, the following: "...has been very tearful, to be seen by house psyc (psychiatrist) for recommend (recommendations) for depression." Nurses notes, dated 1/7/11 at 0630 (6:30 A.M.): "Res continues with Hospice care. Res. Was	F 250	Systemic change will include completing the Mental Health Wellness Circumstance, Assessment, and Intervention form when a new or an exacerbation of a behavior occurs. **Completion Date 2-16-2011** SSD and /or designee will print group behavior detail report daily to assure the Mental Health Wellness Circumstance, Assessment, and Intervention form was completed when indicated to assure behaviors and psychosocial needs were documented, monitored, and addressed. Results of daily audits will be forwarded monthly to QA for 6 months and quarterly thereafter for further suggestion/recommendations based on compliance. **Completion Date 2-16-2011**	

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F 250	Continued From page 8 crying and stating 'I want to go home'...Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while talking to staff...." Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "...res remains tearful, frequently stating 'Please Lord, take me home'...unable to determine cause for tears ...Hospice kept advised ...Dr. (physician name) updated." Hospice nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11...." On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident was crying and stated, "Help me, I want to die." CNA #7 stated, "You're OK." The resident continued to cry and stated, "I can't do nothing right anymore. I just want to die." CNA #8 stated "Oh, honey." The resident then stated, "I don't know how I got in such a mess." Neither CNA responded. At 10:05 A.M., the resident was repeating "I want to die, I want to die. Oh please God, help me." CNA #7 stated as she worked "We're here for you." The resident began repeating, "I can't stand it." CNA #8 stated, "oh." At 10:07 A.M., the resident was stating, "Oh God, take me home. I want to die. I can't handle it." Neither CNA responded verbally as they assisted the resident to get out of bed. At 10:10 A.M., the resident was sitting on the side	F 250		

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F 250	Continued From page 9 of her bed with CNA #7 and CNA #8 assisting. The resident stated, "Please God, help me. Just throw everything away." CNA #8 stated, "We don't want to do that." The resident then stated, "I'd rather die than anything." Neither CNA responded. On 1/21/11 at 10:55 A.M., the resident was observed to be in her wheelchair in the activity room during an activity with activity staff and other residents. The resident stated, "I wanna die, I wanna die." There was no response from any staff. The resident repeated, "I wanna die, I wanna die." Activity Staff #1 stated, "No you don't," as she walked by the resident. On 1/21/11 at 9:30 A.M., copies of the resident's social service notes were received from the MDS coordinator. These notes indicated the following: "9/2/10 : ...Emergency admitted (sic) from home ...9/5/10: Resident is noted to be anxious this day and expressing paranoid thoughts ...talks of calling 911 for police. Tearful, refuses lunch intake and state that food is poisonous...9/8/10: Reported per nursing staff resident pilfering in room mate's belongings and having paranoid thoughts...Dr...contacted with orders...per inpatient behavioral setting...9/10/10: Resident...to...Behavioral Health for inpatient treatment...9/15/10: Resident readmitted...from...behavioral health...9/22/10: ...resident was readmitted on 9/15/10 from...behavioral health where she had been treated for psychosis, behavioral disturbances and alz (Alzheimer) type dementia...." The most recent social service note was dated 12/17/10 and included, but was not limited to, the following: "order received to place Zyprexia on	F 250		

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F 250	Continued From page 10 hold...." On 1/21/11 at 10:40 A.M., the DON (Director of Nursing) was interviewed. She indicated staff document the resident's behaviors in the KIOSK (facility computer system). On 1/21/11 at 10:50 A.M., the Social Service Director (SSD) was interviewed. She indicated the resident "not having any behaviors currently to monitor, so they don't have a care plan to address her behaviors." On 1/24/11 at 1:30 P.M., the SSD was interviewed. She indicated the "first trigger" to monitoring the resident's behaviors would be the CNAs (certified nursing assistants) would indicate the resident's behaviors by entering them on the KIOSK. The SSD indicated the resident was admitted to the facility on 9/2/10 and was admitted to the behavior unit from 9/10 to 9/15/10. She also indicated the resident did not have any behaviors documented in the KIOSK for the year 2010. The SSD indicated the reason the resident was sent to the behavior unit was due to expressing anxious, paranoid thoughts and was tearful. She indicated the resident's behaviors should have been tracked if the CNAs put them in the KIOSK. The SSD indicated she "knew (resident name) had the behaviors, because I observed them myself." She indicated the main way she is made aware of the resident's behaviors is from the KIOSK. She indicated she is also made aware of resident behaviors through her observation and staff telling her of incidents. She indicated, when she is not in the building and staff do not enter behaviors in the KIOSK, she wouldn't be informed of the behavior.	F 250		

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F 250	Continued From page 11 On 1/21/11 at 10:50 A.M. a copy of the resident's KIOSK "Group Behavior Chart" for January 2011 was reviewed. No incidents were documented for the month to date. On 1/24/11 at 1:20 P.M., a policy and procedure for "Social Assessment" was received from the ADON (Assistant Director of Nursing). This policy was undated. The policy included, but was not limited to, the following: "A social assessment must be conducted to assist in identifying the resident's personal and social problems significant to the resident's course of treatment...Assessment should include an evaluation of the following areas: ...Psychosocial functioning to include: emotional stance toward: self and situation, family and others and institutional environment ...Data obtained from the social assessment must be used to develop the social services portion of the comprehensive care plan...." On 1/24/11 at 2:30 P.M., the resident's "Group Behavior Chart" from the KIOSK was reviewed for September 2010 through January 2011. The categories of this chart included the following: "wandering, wandering alterable, verb (verbal) abuse, verb. Alterable, phys. (physical) abuse, phys. Alterable, soc (socially) inap. (inappropriate), soc inap. Alterable, resists care, resist alterable." For the year 2010, there was one incident documented for physical abuse and one incident of phys. alterable. On 1/25/11 at 10 A.M., the DON and Administrator were interviewed. They indicated the resident had been on the CAR (Clinically at Risk) program from 9/16/10 until 11/10/10 for behaviors. They indicated the resident's	F 250		

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	155361	A. BUILDING _____ B. WING _____	01/25/2011

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F 250	Continued From page 12 behaviors stabilized, but the resident then remained on the CAR program due to her weight issues. The DON and Administrator indicated the resident was restarted on the CAR program for behaviors on 12/29/10. They provided the most recent copy of the resident's CAR notes from 1/20/11. These notes only addressed the resident's weight and were lacking documentation of the behaviors as observed on 1/19/11. The weekly follow up for this date indicated, "Resident's behavior patterns remain stable. Continue current interventions; and Resident continues to exhibit behavior concerns. See below for updated interventions" and were both left unmarked for the 1/20/11 assessment date. Both the Administrator and DON indicated they were aware of the lack of behavior documentation and/or monitoring.	F 250		
F 272 SS=D	3.1-34(a) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	F 272 Res #14 no longer resides in the campus. Resident #3 was evaluated by therapy and plan was as followed resident ambulates independently with a rolling walker but chooses not to due to her confidence level and history of falls. She requires encouragement to walk independently or ask for assistance when she so desires. No further therapy intervention is indicated at this time. Resident was placed on a restorative program. Resident # 41's skin impairments from the fall are now healed **Completion Date 2-16-2011**	

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F 272	Continued From page 13 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview and record review, the facility failed to accurately assess a blister and/or shearing areas as pressure sores for 1 of 2 residents reviewed for pressure sores in a sample of 14. Resident #14 B. Based on observation, interview and record review, the facility failed to assess and monitor resident behaviors and/or psychosocial needs for 1 of 3 residents reviewed for behaviors in a sample of 14. Resident #14 C. Based on observation, record review and interview, the facility failed to assess the ambulation needs of 1 of 1 resident requesting ambulation services from a sample of 14. Resident # 3 D. Based on observation, interview and record review, the facility failed to ensure an accurate	F 272	All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure accurate assessments. **Completion Date 2-16-2011** A skin sweep has been preformed in the campus on all residents to assure all skin impairments have been accurately identified and assessed. All nurses have been in-serviced related to assessment of skin impairment and timely skin assessments. Nursing staff have been in serviced on using the skin examination reporting tool for timely identification of skin impairments. All campus staff has been in serviced on appropriate response to a behavior and required documentation of that behavior. Campus nurses have been in serviced on using the new assessment titled Mental Wellness Circumstance, Assessment and Intervention form when a new or an exacerbation of a behavior occurs.	

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F 272	Continued From page 14 skin assessment was completed promptly after a resident had a fractured right arm for 1 of 1 resident reviewed with a fracture in a sample of 14. Resident #41 Findings include: A. The clinical record of Resident #14 was reviewed on 1/18/11 at 3:10 P.M. Diagnoses included, but were not limited to, the following: anemia, B12 deficiency, muscle weakness, dementia with behavioral disturbance and psychosis. The MDS (minimum data set assessment) dated 1/3/11, indicated the following for the resident: cognition summary score was totaled to be zero, which indicated a severely impaired cognition status; was at risk for developing pressure sores; bed mobility required extensive assistance (resident involved in activity, staff provide weight-bearing support); ambulation in room and corridor didn't occur; resident always incontinent of bowel and bladder. Upon entrance into the building, the facility-provided roster sample/matrix, did not indicate this resident had a pressure sore. An ADL (activities of daily living) care plan, dated 9/15/10, indicated the following: "Needs assistance or is dependent in: bed mobility, transfer...personal hygiene..." The intervention of "turn and reposition, shifting weight to enhance circulation" was left unchecked and not identified as an intervention. A care plan, which addressed the problem of "potential alteration in skin integrity" was dated 9/15/10. Interventions which were listed as an option, but were left blank and not included, were	F 272	All residents in the campus with the ability to ambulate have been screened by therapy to assess ambulation needs. **Completion Date 2-16-2011** Systemic changes nursing staff to complete the skin examination reporting tool and forward to the nurse to complete assessment of new skin impairment. Systemic change will include completing the Mental Health Wellness Circumstance, Assessment, and Intervention form when a new or an exacerbation of a behavior occurs. Systemic change to include therapy to complete quarterly screens for residents with the ability to ambulate to assess ambulation needs and assure needs met. **Completion Date 2-16-2011**	

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F 272	Continued From page 15 "turn and reposition." Nurses notes, dated 12/17/10, at 10 A.M. indicated the following: "...R (right) hip noted to have a red sheared area..." A form titled "Other Skin Impairment Assessment" was dated 12/17/10. This form identified the areas as follows: Not present on admission; type: shearing; Location on right hip: length: 0.3; width 0.2; depth <0.2 (sic). The most recent weekly measurement was on 1/17/11 and indicated a length of 1.2; width of 1.3 and depth of "E." On 1/25/11 at 1 P.M., the DON (Director of Nursing) was interviewed. She indicated the "E" for depth indicated yellow drainage. A Pressure Ulcer Letter of Unavoidability was dated 12/27/10. This form indicated the following: "Clinical conditions this resident exhibit that makes the likelihood of this pressure ulcer unavoidable include but are not limited to, resident immobility and: Hospice, no code; continuous urinary incontinence; dementia, adult failure to thrive, hgb (hemoglobin) less than 12 mg/dl (milligrams per deciliter), pale skin, poor skin turgor and resd (resident) lies in fetal position, attempts to get resd to lie extended without success." A physician order, dated 12/29/10, indicated the following: "Apply skin prep to water filled blister on upper thigh daily x 7 days..." On 1/19/11 at 9:30 A.M., CNA #8 was interviewed. She indicated the resident "had a sore" on her right hip and they needed to keep the resident off that side.	F 272	DHS/Designee will review the skin examination reporting tool to assure accurate and timely assessment of skin impairments 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. SSD and /or designee will print group behavior detail report daily to assure the Mental Health Wellness Circumstance, Assessment, and Intervention form was completed when indicated to assure behaviors and psychosocial needs were documented, monitored, and addressed. Results of daily audits will be forwarded monthly to QA for 6 months and quarterly thereafter for further suggestion/recommendations based on compliance. ED and /or designee to review quarterly screens to assure completion and recommendations are followed to meet the residents ambulation needs with results being forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 2-16-2011**	

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F 272	Continued From page 16 The resident's care was observed on 1/19/11. At 10 A.M., CNA #7 and CNA #8 were observed assisting the resident to check and change her brief. With the resident on her back, they untaped the tabs on both sides of the brief. The resident was rolled to her right side. CNA #7 then began rolling up the left side of the resident's brief, until the rolled brief was close to the resident's skin. CNA #7 then applied pressure to the resident's left hip and with CNA #7's hand, she pulled the brief out from under the resident's right hip, which was planted on the bed. As the brief was removed from underneath the resident, the brief was stretched taught upon removal, creating a shearing effect. A dressing was observed to the resident's right hip dated 1/19/11. At 2 P.M., CNA #7 and CNA #8 again assisted the resident by checking and changing her brief. Again, the CNAs assisted the resident as observed at 10 A.M. by rolling up the left side of the resident's brief, until the rolled brief was close to the resident's skin. CNA #7 then applied pressure to the resident's left hip and with CNA #7's hand, she pulled the brief out from under the resident's right hip, which was planted on the bed. As the brief was removed from underneath the resident, the brief was stretched taught upon removal, creating a shearing effect. On 1/21/11 at 10:40 A.M., the DON (Director of Nursing) was interviewed. She indicated the open area on the resident's right hip was a result of shearing from the brief. On 1/24/11 at 3:20 P.M., the DON provided a current, undated copy of the facility's policy and procedure for "Wound Staging and Identification	F 272		

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F 272	Continued From page 17 Education Information." This policy included, but was not limited to, the following: "Pressure ulcers as defined...as a result of pressure in combination with shear and friction. Pressure wounds should be classified by describing the degree of tissue damage observed; Stage II:...may present as a blister..." Documentation was lacking of an accurate assessment to identify the blister and shearing areas as being pressure sores. B. The clinical record of Resident #14 was reviewed on 1/18/11 at 3:10 P.M. Diagnoses included, but were not limited to, the following: dementia with behavioral disturbances and psychosis. The most recent MDS (Minimum Data Set assessment) dated 12/31/10, indicated the following for the resident: cognitive summary score was zero, which indicated a severe cognitive impairment; symptoms present of mood were identified as "no response." A psychiatric evaluation, dated 9/11/10, indicated the following: Diagnoses: "...beh (behavioral) disturbances/psychosis...anxiety/...dep (depressive) disorder...initial treatment plan: increase Zyprexa (antipsychotic medication) to 5 mg bid (twice a day)...c/o (complaints of): ...referred from medical floor after she received blood transfusion. She originally came from (name of nursing home) through the ER (for low hemoglobin) ...Res (resident) very paranoid, yelling ...symptoms: depressed, crying, lack of interest: mental status exam: depressed and scared...." A behavorial health progress note, dated 9/15/10, included, but was not limited to, the following:	F 272		

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F 272	Continued From page 18 "Mood: OK" (depressed was an option but was not checked). A "Hospice" plan of care was dated 12/10/10. Interventions included, but were not limited to, the following: "Allow resident to discuss painful feelings if able. Do not deny death if resident wants to talk about it." Nurses notes, dated 12/28/10 (sic), at 2300 (11 P.M.), indicated the following: "Res (resident) very tearful saying 'I want to go home.' All attempts made to comfort res refused ...Hospice nurse updated on res condition et (and) tearfulness at this tx (time). Hospice nurse stated she would see res in AM (morning) et (and) contact Dr. (physician name) with update." Nurses notes, dated 12/28/10 at 0946 (9:46 A.M.), indicated the following: "Res. cont. (continue) with hospice care services. Res. has been very tearful. Res. has not wanted to eat...." Hospice nurses notes, dated 12/30/10, included, but were not limited to, the following: "tearful at times, tearful, wants to go home...." Hospice nurse notes, dated 1/6/11, included, but were not limited to, the following: "...has been very tearful, to be seen by house psyc (psychiatrist) for recommend (recommendations) for depression." Nurses notes, dated 1/7/11 at 0630 (6:30 A.M.): "Res continues with Hospice care. Res. Was crying and stating 'I want to go home'...Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while talking to staff...."	F 272		

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F 272	Continued From page 19 Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "...res remains tearful, frequently stating 'Please Lord, take me home'...unable to determine cause for tears ...Hospice kept advised ...Dr. (physician name) updated." Hospice nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11...." On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident was crying and stated, "Help me, I want to die." CNA #7 stated, "You're OK." The resident continued to cry and stated, "I can't do nothing right anymore. I just want to die." CNA #8 stated "Oh, honey." The resident then stated, "I don't know how I got in such a mess." Neither CNA responded. At 10:05 A.M., the resident was repeating "I want to die, I want to die. Oh please God, help me." CNA #7 stated as she worked "We're here for you." The resident began repeating, "I can't stand it." CNA #8 stated, "oh." At 10:07 A.M., the resident was stating, "Oh God, take me home. I want to die. I can't handle it." Neither CNA responded verbally as they assisted the resident to get out of bed. At 10:10 A.M., the resident was sitting on the side of her bed with CNA #7 and CNA #8 assisting. The resident stated, "Please God, help me. Just throw everything away." CNA #8 stated, "We don't want to do that." The resident then stated,	F 272		

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F 272	Continued From page 20 "I'd rather die than anything." Neither CNA responded. On 1/21/11 at 9:30 A.M., copies of the resident's social service notes were received from the MDS coordinator. These notes indicated the following: "9/2/10 : ...Emergency admitted (sic) from home ...9/5/10: Resident is noted to be anxious this day and expressing paranoid thoughts ...talks of calling 911 for police. Tearful, refuses lunch intake and state that food is poisonous...9/8/10: Reported per nursing staff resident pilfering in room mate's belongings and having paranoid thoughts...Dr...contacted with orders...per inpatient behavioral setting...9/10/10: Resident...to...Behavioral Health for inpatient treatment...9/15/10: Resident readmitted...from...behavioral health...9/22/10: ...resident was readmitted on 9/15/10 from...behavioral health where she had been treated for psychosis, behavioral disturbances and alz (Alzheimer) type dementia...." The most recent social service note was dated 12/17/10 and included, but was not limited to, the following: "order received to place Zyprexia on hold...." On 1/21/11 at 10:40 A.M., the DON (Director of Nursing) was interviewed. She indicated staff document the resident's behaviors in the KIOSK (facility computer system). On 1/21/11 at 10:50 A.M., the Social Service Director (SSD) was interviewed. She indicated the resident "not having any behaviors currently to monitor, so they don't have a care plan to address her behaviors."	F 272		

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F 272	Continued From page 21 On 1/24/11 at 1:30 P.M., the SSD was interviewed. She indicated the "first trigger" to monitoring the resident's behaviors would be the CNAs (certified nursing assistants) would indicate the resident's behaviors by entering them on the KIOSK. The SSD indicated the resident was admitted to the facility on 9/2/10 and was admitted to the behavior unit from 9/10 to 9/15/10. She also indicated the resident did not have any behaviors documented in the KIOSK for the year 2010. The SSD indicated the reason the resident was sent to the behavior unit was due to expressing anxious, paranoid thoughts and was tearful. She indicated the resident's behaviors should have been tracked if the CNAs put them in the KIOSK. The SSD indicated she "knew (resident name) had the behaviors, because I observed them myself." She indicated the main way she is made aware of the resident's behaviors is from the KIOSK. She indicated she is also made aware of resident behaviors through her observation and staff telling her of incidents. She indicated, when she is not in the building and staff do not enter behaviors in the KIOSK, she wouldn't be informed of the behavior. On 1/21/11 at 10:50 A.M. a copy of the resident's KIOSK "Group Behavior Chart" for January 2011 was reviewed. No incidents were documented for the month to date. On 1/24/11 at 1:20 P.M., a policy and procedure for "Social Assessment" was received from the ADON (Assistant Director of Nursing). This policy was undated. The policy included, but was not limited to, the following: "A social assessment must be conducted to assist in identifying the resident's personal and social problems significant to the resident's course of	F 272		

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F 272	Continued From page 22 treatment...Assessment should include an evaluation of the following areas: ...Psychosocial functioning to include: emotional stance toward: self and situation, family and others and institutional environment ...Data obtained from the social assessment must be used to develop the social services portion of the comprehensive care plan...." On 1/24/11 at 2:30 P.M., the resident's "Group Behavior Chart" from the KIOSK was reviewed for September 2010 through January 2011. The categories of this chart included the following: "wandering, wandering alterable, verb (verbal) abuse, verb. Alterable, phys. (physical) abuse, phys. Alterable, soc (socially) inap. (inappropriate), soc inap. Alterable, resists care, resist alterable." For the year 2010, there was one incident documented for physical abuse and one incident of phys. alterable. On 1/25/11 at 10 A.M., the DON and Administrator were interviewed. They indicated the resident had been on the CAR (Clinically at Risk) program from 9/16/10 until 11/10/10 for behaviors. They indicated the resident's behaviors stabilized, but the resident then remained on the CAR program due to her weight issues. The DON and Administrator indicated the resident was restarted on the CAR program for behaviors on 12/29/10. They provided the most recent copy of the resident's CAR notes from 1/20/11. These notes only addressed the resident's weight and were lacking documentation of the behaviors as observed on 1/19/11. The weekly follow up for this date indicated, "Resident's behavior patterns remain stable. Continue current interventions; and Resident continues to exhibit behavior concerns. See	F 272		

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F 272	Continued From page 23 below for updated interventions" and were both left unmarked for the 1/20/11 assessment date. Both the Administrator and DON indicated they were aware of the lack of behavior documentation and/or monitoring. Documentation was lacking of an assessment of the resident's psychosocial needs and behaviors as related to her depressive mood and crying. C. The facility provided a roster of residents on 1/18/11 which identified Resident #3 as alert, oriented and reliable for interview. Resident #3 was interviewed on 1/24/11 at 2:30 P.M. The resident indicated "The girls (CNA staff) are supposed to give me a chance to walk twice a day but they don't. We have a walker and they got a belt (gait belt safety device) but they don't get it done. I used to go to therapy but my time ran out. I was able to do real good then but I don't get the practice and I'm wobbly now. I wish I could practice some just here in the hall if they'd let me." The clinical record of Resident #3 was reviewed on 1/24/11 at 2:00 P.M. The Minimum Data Set Assessment (MDS) of 1/06/11 indicated the resident was cognitively normal and the activity of ambulating in the corridor had not occurred during the assessment period. Resident #3 had been discharged from Physical therapy (PT) on 5/12/10 ambulating with slightly stooped posture, using a rolling walker and CGA (care giver assistance), for a distance of 90 to 100 feet. Documentation was lacking in the medical record to indicate an accurate assessment of nursing ambulation assistance needs had been instituted	F 272		

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	155361	A. BUILDING _____ B. WING _____	01/25/2011

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F 272	Continued From page 24 after the PT was discontinued. Documentation of the "RESIDENT FIRST CONFERENCE NOTES" on 9/1/10 was a summary tool completed at the time of care plan update. It indicated "ambulates with SBA (stand by assistance) in the hall." The ADL (activity of daily living) documentation by CNAs computer entries was reviewed from the month preceding from 8/1/10 to 9/01/10. The resident had been documented to have ambulated in the hall three times, requiring limited assistance. The care plan since 10/26/10 indicated an ADL self care deficit of "Needs assistance or is dependent in transfer and walking;" however, the intervention of Restorative Nursing or walking assistance had not been checked. The CNA ADL documentation from 12/01/10 through 1/24/11 indicated the resident had ambulated once with assistance in that interval. The CNA assignment sheet in use on 1/25/11 provided directions for the care of Resident #3. The restorative section was left blank. On 1/25/11 at 10:30 A.M. after being made aware of the resident request, CNA #6 assisted the resident to ambulate in the corridor using a gait belt and a rolling walker. The resident initially had hesitant gait, requiring assistance to stabilize but gradually required stand by assistance with occasional cueing to correct stooped posture. The resident was able to ambulate approximately 75 feet, sit to rest when cued by the CNA and directed to a chair and then walk 75 feet back to her room. CNA #6 indicated the resident was walked "if she tells us when she wants, but no planned walking, just when she asks."	F 272		

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F 272	Continued From page 25 Documentation was lacking to indicate there had been assessment of the problem of the resident's ambulation status and not being walked. On 1/25/11 at 12:20 P.M., the Director of Nursing indicated the resident was able to request assistance when she wanted to walk and had been relied upon to make the request. D. Resident #41's clinical record was reviewed on 1/18/11 at 11:56 A.M. Her current Minimum Data Set assessment (MDS) dated 1/3/11, indicated a severe cognitive impairment, assistance of staff for transfers and ambulation, and no range of motion impairment of upper and lower extremities. A nursing note dated 1/12/11 at 3:00 P.M., indicated, "Res (resident) found on floor. C/O (complaint) R (right) shoulder et elbow pain. ST (skin tear) to L (left) elbow 1.7 x 2.2 cm. Bumped head-neuro (check) initiated WNL (within normal limits). V/S (vital signs) 97.9 (temperature)-78 (pulse)-20 (respirations)...." A Fall Circumstance Assessment and Intervention form dated 1/12/11 at 3:00 P.M., indicated a skin tear of the left elbow and no injury of bruising. Assessment included but was not limited to a complaint of pain of the right shoulder and elbow. A radiology report dated 1/12/11, indicated an acute right humerus fracture. A nursing note dated 1/12/11 at 10:00 P.M., indicated,"X ray completed MD notified. R (right) arm wrapped close to res (resident) body per MD	F 272		

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F 272	Continued From page 26 request." Documentation was lacking of a right arm assessment after the fall of 1/12/11 until a Skin Impairment Circumstance, Assessment and an Intervention and an Other Skin Impairment Assessment were initiated on 1/18/11. The Skin Impairment Circumstance, Assessment and Intervention dated 1/18/11, indicated, bruises of the left elbow and the right upper extremities. No measurement of bruising was documented. The Other Skin Impairment Assessment dated 1/18/11, indicated left elbow and right arm and side had scattered bruises. No measurements were documented. On 1/19/11 from 9:00 A.M., to 2:05 P.M., Resident #41's care was observed. On 1/19/11 at 10:20 A.M., LPN # 1 assisted Resident #41 with repositioning of the right arm sling. Bruising was observed of the right outer arm from approximately the shoulder area to elbow area(ranging from yellow to purple discoloration) and the right torso area approximately the axilla areae to the mid trunk (purple discoloration). No measurements were documented. On 1/21/11 at 9:45 A.M., the Director of Nursing(DON) with the assistance of the Assistant Director of Nursing(ADON) measured the bruising of the right upper extremity. These measurements were recorded on 1/21/11, on the form Other Skin Impairment Assessment which had been initiated on 1/18/11. The right outer upper extremity bruising was measured as 40.8 cm length x 30 cm width with largely faint yellow	F 272		

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F 272	Continued From page 27 with small amount of purple at the antecubital area. The bruising of the right side of the torso was measured as 20.5 cm length x 10.7 cm width with two thirds of the bruising a purple discoloration and 1/3 a yellow discoloration.	F 272		
F 311 SS=D	3.1-31(a) 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation, the facility failed to provide ambulation services for 1 of 1 resident requesting the services from a sample of 14. Resident #3 Findings include: The facility provided a roster of residents on 1/18/11 which identified Resident #3 as alert, oriented and reliable for interview. Resident #3 was interviewed on 1/24/11 at 2:30 P.M. The resident indicated "The girls (CNA staff) are supposed to give me a chance to walk twice a day but they don't. We have a walker and they got a belt (gait belt safety device) but they don't get it done. I used to go to therapy but my time ran out. I was able to do real good then but I don't get the practice and I'm wobbly now. I wish I could practice some just here in the hall if they'd let me. Maybe they are afraid since I fell once when my knee gave out, but I should be OK with	F 311	F 311 Resident #3 was evaluated by therapy and plan was as followed resident ambulates independently with a rolling walker but chooses not to due to her confidence level and history of falls. She requires encouragement to walk independently or ask for assistance when she so desires. No further therapy intervention is indicated at this time. Resident was placed on a restorative program. **Completion Date 2-16-2011** All residents in the campus with the ability to ambulate have been screened by therapy to assess ambulation needs and assure needs met. **Completion Date 2-16-2011** Systemic change to include therapy to complete quarterly screens for residents with the ability to ambulate to assess ambulation needs and assure needs met. **Completion Date 2-16-2011**	

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F 311	Continued From page 28 two girls. They are nice but have more than they can do." The clinical record of Resident #3 was reviewed on 1/24/11 at 2:00 P.M. The Minimum Data Set Assessment (MDS) of 1/06/11 indicated the resident was cognitively normal and the activity of ambulating in the corridor had not occurred during the assessment period. Resident #3 had been discharged from Physical therapy (PT) on 5/12/10 ambulating with slightly stooped posture, using a rolling walker and CGA (care giver assistance), for a distance of 90 to 100 feet. Documentation was lacking in the record to indicate any planned program of walking opportunity had been instituted after the PT was discontinued. Documentation of the "RESIDENT FIRST CONFERENCE NOTES" on 9/1/10 was a summary tool completed at the time of care plan update. It indicated "ambulates with SBA (stand by assistance) in the hall." The ADL (activity of daily living) documentation by CNAs computer entries was reviewed from the month preceding from 8/1/10 to 9/01/10. The resident had been documented to have ambulated in the hall three times, requiring limited assistance. The care plan since 10/26/10 indicated an ADL self care deficit of "Needs assistance or is dependent in transfer and walking;" however, the intervention of Restorative Nursing or walking assistance had not been checked. The CNA ADL documentation from 12/01/10 through 1/24/11 indicated the resident had ambulated once with assistance in that interval.	F 311	ED and /or designee to review quarterly screens to assure completion and recommendations are followed to met the residents ambulation needs with results being forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 2-16-2011**	

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F 311	Continued From page 29 The CNA assignment sheet in use on 1/25/11 provided directions for the care of Resident #3. The restorative section was left blank. On 1/25/11 at 10:30 A.M. after being made aware of the resident request, CNA #6 assisted the resident to ambulate in the corridor using a gait belt and a rolling walker. The resident initially had hesitant gait, requiring assistance to stabilize but gradually required stand by assistance with occasional cueing to correct stooped posture. The resident was able to ambulate approximately 75 feet, sit to rest when cued by the CNA and directed to a chair and then walk 75 feet back to her room. CNA #6 indicated the resident was walked "if she tells us when she wants, but no planned walking, just when she asks." Documentation was lacking to indicate there had been assessment of the problem of the resident's ambulation status and not being walked. On 1/25/11 at 12:20 P.M., the Director of Nursing indicated the resident was able to request assistance when she wanted to walk and had been relied upon to make the request. to walk and had been relied upon to make the request.	F 311		
F 314 SS=D	3.1-38(a)(2)(B) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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F 314	Continued From page 30 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure measures to prevent the development of pressure sores were followed for 1 of 1 resident reviewed with facility-acquired pressure sores in a sample of 14. Resident #14 Findings include: The clinical record of Resident #14 was reviewed on 1/18/11 at 3:10 P.M. Diagnoses included, but were not limited to, the following: anemia, B12 deficiency, muscle weakness, dementia with behavioral disturbance and psychosis. The MDS (minimum data set assessment) dated 1/3/11, indicated the following for the resident: cognition summary score was totaled to be zero, which indicated a severely impaired cognition status; was at risk for developing pressure sores; bed mobility required extensive assistance (resident involved in activity, staff provide weight-bearing support); ambulation in room and corridor didn't occur; resident always incontinent of bowel and bladder. Upon entrance into the building, the facility-provided roster sample/matrix, did not indicate this resident had a pressure sore. An ADL (activities of daily living) care plan, dated 9/15/10, indicated the following: "Needs assistance or is dependent in: bed mobility,	F 314	**F 314** Resident #14 no longer resides in campus **Completion Date 2-16-2011** All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent the development of pressure sores. **Completion Date 2-16-2011** Nursing staff have been in serviced on pressure ulcer prevention. Current nursing staff will complete a return demonstration for removal of a soiled brief on a resident in bed. **Completion Date 2-16-2011** Systemic change annually campus will have brief vendor complete in service on proper application and removal of briefs. **Completion Date 2-16-2011**	

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F 314	Continued From page 31 transfer...personal hygiene..." The intervention of "turn and reposition, shifting weight to enhance circulation" was left unchecked and not identified as an intervention. A care plan, which addressed the problem of "potential alteration in skin integrity" was dated 9/15/10. Interventions which were listed as an option, but were left blank and not included, were "turn and reposition." Nurses notes, dated 12/17/10, at 10 A.M. indicated the following: "...R (right) hip noted to have a red sheared area..." A form titled "Other Skin Impairment Assessment" was dated 12/17/10. This form identified the areas as follows: Not present on admission; type: shearing; Location on right hip: length: 0.3; width 0.2; depth <0.2 (sic). The most recent weekly measurement was on 1/17/11 and indicated a length of 1.2; width of 1.3 and depth of "E." On 1/25/11 at 1 P.M., the DON (Director of Nursing) was interviewed. She indicated the "E" for depth indicated yellow drainage. A Pressure Ulcer Letter of Unavoidability was dated 12/27/10. This form indicated the following: "Clinical conditions this resident exhibit that makes the likelihood of this pressure ulcer unavoidable include but are not limited to, resident immobility and: Hospice, no code; continuous urinary incontinence; dementia, adult failure to thrive, hgb (hemoglobin) less than 12 mg/dl (milligrams per deciliter), pale skin, poor skin turgor and resd (resident) lies in fetal position, attempts to get resd to lie extended without success."	F 314	DHS or designee will perform random audits of C.N.A. care to assure following standards of care to prevent pressure ulcers on 3 random residents 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 2-16-2011**	

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F 314	Continued From page 32 A physician order, dated 12/29/10, indicated the following: "Apply skin prep to water filled blister on upper thigh daily x 7 days..." On 1/19/11 at 9:30 A.M., CNA #8 was interviewed. She indicated the resident "had a sore" on her right hip and they needed to keep the resident off that side. The resident's care was observed on 1/19/11. At 10 A.M., CNA #7 and CNA #8 were observed assisting the resident to check and change her brief. With the resident on her back, they untaped the tabs on both sides of the brief. The resident was rolled to her right side. CNA #7 then began rolling up the left side of the resident's brief, until the rolled brief was close to the resident's skin. CNA #7 then applied pressure to the resident's left hip and with CNA #7's hand, she pulled the brief out from under the resident's right hip, which was planted on the bed. As the brief was removed from underneath the resident, the brief was stretched taught upon removal, creating a shearing effect. A dressing was observed to the resident's right hip dated 1/19/11. At 2 P.M., CNA #7 and CNA #8 again assisted the resident by checking and changing her brief. Again, the CNAs assisted the resident as observed at 10 A.M. by rolling up the left side of the resident's brief, until the rolled brief was close to the resident's skin. CNA #7 then applied pressure to the resident's left hip and with CNA #7's hand, she pulled the brief out from under the resident's right hip, which was planted on the bed. As the brief was removed from underneath the resident, the brief was stretched taught upon removal, creating a shearing effect.	F 314		

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F 314	Continued From page 33 On 1/21/11 at 10:40 A.M., the DON (Director of Nursing) was interviewed. She indicated the open area on the resident's right hip was a result of shearing from the brief. On 1/24/11 at 3:20 P.M., the DON provided a current, undated copy of the facility's policy and procedure for "Wound Staging and Identification Education Information." This policy included, but was not limited to, the following: "Pressure ulcers as defined...as a result of pressure in combination with shear and friction. Pressure wounds should be classified by describing the degree of tissue damage observed; Stage II:...may present as a blister..." On 1/25/11 at 1:30 P.M., the DON provided a copy of the "other skin impairment assessment" form dated 12/29/10. This form indicated the following for the resident: "Not present on admission; type: blister; location: left hip: length: 1 cm and width 2 cm...1/10/11 area was healed." 3.1-40(a)(2)	F 314		